P A T H

Department of Prevention, Assistance, Transition, and Health Access

B U L L E T I N NO. 02-22F

FROM Eileen I. Elliott, Commissioner
for the Secretary

DATE 6/14/02

SUBJECTS Changes to Cost-Sharing Requirements for Vermont Health Access Plan (VHAP) and VScript and Suspension of Vision Benefit

CHANGES ADOPTED EFFECTIVE 7/1/02

INSTRUCTIONS

X **Maintain Manual - See instructions below.**

___ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**

___ **Information or Instructions - Retain until _____**

MANUAL REFERENCE(S)

4001.92 3203 3305 P.2
3303.1 P. 2 M670

State legislation requires the department to adopt the cost-saving measures authorized in the budget act (H.766). This rule increases or establishes VHAP cost-sharing requirements for services provided by physicians, chiropractors, and other practitioners; physical, occupational, speech, and nutrition therapy visits; hospital inpatient and outpatient services; and emergency room visits that are not medically necessary. It also establishes a deductible for VScript Expanded beneficiaries, copayments for generic and nongeneric prescription drugs under VHAP and VScript, including VScript Expanded, and suspends coverage of frames, lenses, and refraction exams provided by optometrists except when prior approved, for adults under all health assistance programs for one year.

The following table summarizes the changes in cost-sharing.

Program	Type of Service	Current Cost-Sharing	Proposed Cost-Sharing
VHAP-Pharmacy	Generic drug prescriptions	$1-$3	$3.00
	Nongeneric drug prescriptions	$1-$3	$6.00
VScript	Generic drug prescriptions	$2-$4	$5.00
	Nongeneric drug Prescriptions	$2-$4	$10.00

Program	Type of Service	Current Cost-Sharing	Proposed Cost-Sharing
VScript-Expanded	Deductible	None	$275 per year
	Prescriptions	41%	41%
VHAP	Physician visits	$2	$7
	Chiropractor visits	$2	25% ($3.50 per subluxation)
	Other practitioners	$2	$7
	Therapy visits	$2	$7
	Home Health Visits	$2	None
	Hospital inpatient	None	$50 per admission
	Hospital outpatient	$3 per day	$25 per day
	Emergency room visit, not medically necessary	$25	$60

Specific Changes to Existing Regulations

VHAP 4001.92 — Increases or establishes VHAP cost-sharing requirements for services provided by physicians, chiropractors, and other practitioners; physical, occupational, speech, and nutrition therapy visits; hospital inpatient and outpatient services; and emergency room visits that are not medically necessary. Changes in response to comments: Eliminate home health services $2.00 copayment per visit; add reference to M103.3 (13) and (37) to define emergency; Add actual chiropractic coinsurance cost of $3.50 per subluxation.; strike "to the pharmacy" from note on failure to pay coinsurance.

VScript 3203 — Establishes a deductible for VScript Expanded beneficiaries, establishes copayments for generic and nongeneric prescription drugs. Changes in response to comments: Clarify that the $2,500 annual out-of-pocket maximum includes both the $275 deductible as well as the coinsurance.

VHAP-Pharmacy 3303.1 P.2 and 3305 P.2 — Establishes copayments for generic and nongeneric prescription drugs. Changes in response to comments: Clarify that the $50.00 per quarter maximum copayment applies to both drugs and diabetic supplies. Since filing the final proposed rules and with the approval of the Joint Legislative Committee on Administrative Rules: Applies specific details of limits on coverage to eyeglasses and vision care services, including the fact that refraction exams may be covered if billed by a physician, or if billed by an optometrist with prior approval.

M670 Suspends coverage of frames, lenses, and refraction exams for one year. Changes in response to comments: Add to M670.3 clarification that only the refraction exam code is suspended and clarifies that the dispensing fees are also suspended. Since filing the final proposed rules and with the approval of the Joint Legislative Committee on Administrative Rules: Clarifies that refraction exams are suspended only when provided by an optometrist, unless prior authorized; Defines adults as Medicaid beneficiaries age 21 and older; Notes that limits on coverage to eyeglasses and vision care services outlined in M670.3 applies to all of M670.

VHAP 4003.1 Since filing the final proposed rules and with the approval of the Joint Legislative Committee on Administrative Rules: Clarifies that routine eye exams and eyeglasses are suspended for one year.

Summary of Written Comments

VScript 3203

Comment: Three commenters requested clarification about how the $275 annual deductible would be calculated, and if it would be applied to the $2,500 annual out of pocket maximum.

Response: The rule was revised to clarify that both the deductible and coinsurance would be included in calculating the annual maximum. All out-of-pocket expenses will be tracked on a fiscal year basis by the claims processing system from submitted claims. As soon as the $275 deductible is met by VScript Expanded beneficiaries, they will begin receiving the full benefit.

Comment: One commenter requested an interpretation of the section of the rule which states "A pharmacy shall dispense a drug to an eligible beneficiary upon payment of the required co-payment or co-insurance," to mean that a pharmacy may refuse service under VScript until the co-payment is paid.

Response: The department believes that if the beneficiary is given sufficient advance notice, a pharmacy may refuse service because of past non-payment of required co-payments or co-insurance.

Comment: One commenter was concerned that the rule accurately reflect the statute, which states the coinsurance for VScript expanded beneficiaries is "50% of the Medicaid cost of the drug net of rebates."

Response: In rule, we have elected to use the new legislative language. In practice, the method for computing the coinsurance remains the same, and it currently amounts to 41% of the Medicaid cost of the drug (after necessary rounding down). The bulletin cover sheet has been revised to make clear that no change in payment is expected.

VHAP-Pharmacy 3303.1 P.2

Comment: One commenter was concerned that the expenses that may be used to meet the quarterly out of pocket maximum weren't clearly outlined in the rule.

Response: The rule was modified to clarify that the copayments for both drugs and diabetic supplies would be included in the per quarter maximum.

VHAP-Pharmacy 3305 P.2

Comment: Four commenters asked for clarification regarding the suspension of vision benefits, specifically the concern that the rule accurately reflect that only refraction exams and eyewear are suspended for a year.

Response: The vision benefit under VHAP-Pharmacy only covered refraction exams and eyewear. For this reason, the entire vision benefit is suspended under this program. Examination of the eye is still a covered benefit under Medicare.

VHAP 4001.92

Comment: One commenter noted that an increase in copayments from $2 to $7 may have a negative effect on physicians and other practitioners' ability to collect these funds, but no change in the rule was requested.

Comment: One commenter believed that the statute had removed the $2.00 per visit copayment for home health services.

Response: The statute was less than clear on this issue. The department now believes that dropping that copayment was intended. The rule was changed.

Comment: One commenter asked that the definition of "medically necessary emergency" be included in the rule.

Response: The rule has been revised to indicate that M103.3 (13) and (37) which define an "emergency medical condition" and "urgently-needed care", will be used to determine if the ER visit would require a $60 copayment.

Comment: One commenter requested clarification of the 25% chiropractic coinsurance.

Response: The chiropractic benefit only covers one procedure code - a “subluxation”. The actual coinsurance amount would involve pennies, so for the ease of office management, the department determined that a $3.50 per subluxation was more practical and added the amount to the rule.

Comment: One commenter noted that the phrase "to the pharmacy" should be eliminated from the note on failure to pay the coinsurance.

Response: The department agrees and did so.

Comment: One commenter requested that the rule more clearly state that the $750/$1500 annual maximums do not apply to copayments, but only to coinsurance.

Response: The department believes that the statement “Coinsurance payments are limited to a calendar year maximum of $750 for a single person and $1,500 for VHAP families, …” is sufficiently clear.

M670

Comment: Three commenters asked for clarification of which providers may still bill for vision exams after suspension. One commenter specifically asked the rule to state which service codes providers may still bill.

Response: A phrase has been inserted into the rule to show that only the refraction code 92015 for adults is suspended in that section of coverage." In addition, the department is sending providers very specific billing instructions regarding this rule change.

Comment: One commenter pointed out that the bulletin cover page incorrectly identified rule M670.5 as being changed.

Response: The cover page has been corrected.

Comment: Two commenters asked to define the term "adult" as individuals over age 21.

Response: The department's believes that such an interpretation would be inconsistent with current law. Traditional Medicaid beneficiaries become "adults" at age 21. VHAP beneficiaries, however, are an "adult" at age 18.

Comment: One commenter asserted that the suspended refractive examinations are in fact a mandatory covered service, according to federal law and regulations. No legal argument was offered in support of this assertion.

Response: The department' agrees with the general assembly that these optometry and optician services are in fact optional for adults as indicated in 42 CFR 440.210(a)(1) which describes the required services. See also the Social Security Act 1902 (a)(10).

The department does not necessarily agree or disagree with the following comments. No response is offered because we believe they involve matters that are beyond the scope of this expedited rule.

One commenter asked that the rule clarify that physicians may bill patients for services that are not Medicaid covered services.

One commenter was concerned that the reduction in vision benefits my result in some providers further subsidizing the Medicaid and VHAP programs by providing these services without charge to their patients

One commenter asked that to simplify the task required of providers to notify PATH when beneficiaries fail to pay cost sharing amounts, a reporting field is simply added to already-used EDS or PATH forms, such as a claim form.

One commenter requested that PATH amend its Reach Up policy regulations to permit payment for vision services.

Two commenters asked that beneficiaries be permitted to purchase eyewear at a discounted price, at their own expense, from the department's sole source contractor.

One commenter asked that Vermonters be made aware of any other affordable vision service alternatives, for example the Lion's clubs.

Two commenters asked that the department solicit input from advocates when designing notices to beneficiaries about the changes.

One commenter asked that the state notify beneficiaries that they must demonstrate an inability to pay before federal refusal of service provisions can be applied, and that pharmacies be allowed to treat a Medicaid recipient who has past-due co-payments as they would treat any other patient who has past-due debts. In the absence of these allowances, the commenter asks that PATH seek a federal waiver to allow the state to reimburse pharmacies for uncollected copayments.

Vertical lines in the left margin indicate significant changes. Dotted lines at the left indicate changes to clarify, rearrange, correct references, etc., without changing regulation content.

Three dots at the bottom of a page after the last line of text and three dots at the top of the following page before the first line of text indicate that text has been moved.

Manual Holders: Please maintain manuals assigned to you as follows.

Manual Maintenance

Medicaid Policy

Remove		Insert	
M670	(98-11F)	M670	(02-22F)

Refugee - VHAP Policy

Remove		Insert	
TOC (3200)	(97-4F)	TOC (3200)	(02-22)
3203	(01-18F)	3203	(02-22)
3303.1 P.2	(01-18F)	3303.1 P.2	(02-22)
3305 P.2	(99-12)	3305 P.2	(02-22F)
4001.92	(98-23F)	4001.92	(02-22)
4003.1	(01-18F)	4003.1	(02-22F)

3203 Copayment and Coinsurance Requirements

Benefits under this program shall be subject to a copayment or coinsurance by the beneficiary.

For beneficiaries with incomes of 175 percent of the federal poverty level or less, the copayment will be:

> $5.00 for each generic drug prescription, original or refill, dispensed, or
> $10.00 for each other drug prescription, original or refill, dispensed, up to a maximum copayment of $100.00 per quarter.

For beneficiaries whose VScript group income is greater than 175 percent of the federal poverty level and no greater than 225 percent of the federal poverty level, there will be a $275.00 annual deductible and the coinsurance will be 50 percent of the Medicaid cost of the drug net of rebates up to a total $2500.00 annual out-of-pocket maximum for coinsurance and deductibles..

A pharmacy shall dispense a drug to an eligible beneficiary upon payment of the required copayment or coinsurance.

A drug may also be dispensed to an eligible beneficiary, subject to the required copayment or coinsurance, provided such dispensing is pursuant to and in accordance with any contractual arrangement that the department may enter into or approve for the group discount purchase of drugs. Group discount purchase of drugs means contractual arrangements for the procurement and/or distribution of drugs designed to contain costs which include but need not be limited to volume purchasing through manufacturers, wholesalers or retailers, manufacturers' rebates, or mail order delivery. Contracts will be awarded pursuant to guidelines established by the Agency of Administration in Bulletin 3.5 and subsequent issuances. Prior to the beginning of each fiscal year, the Commissioner shall determine the most practical and cost-effective method of purchasing VScript covered drugs. When a person or business located in Vermont and employing citizens of this state has submitted a bid for the group discount purchase of drugs and has not been selected, the Commissioner of the Department shall record the reason for nonselection. The Commissioner's report shall be a public record available to any interested person. All bids or quotations shall be kept on file in the Commissioner's Office and open to public inspection.

The department shall monitor enrollment in the VScript program on a monthly basis, and shall limit enrollment in the program so that expenditures do not exceed the appropriation available for the program in any fiscal year.

3303 Payment Conditions

3303.1 Cost-Sharing (Continued)

The copayment required is as follows:

- $3.00 for each generic drug dispensed; and
- $6.00 for each other drug dispensed.

- $1.00 for each diabetic supply having a usual and customary charge of $29.99 or less;
- $2.00 for each diabetic supply having a usual and customary charge of $30.00 or more;
- $3.00 for each diabetic supply having a usual and customary charge of $50.00 or more.

The maximum copayment is $50.00 per calendar quarter.

The beneficiary's copayment will be deducted from the amount computed to be the VHAP-Pharmacy payment.

3303.2 Lower of Price for Ingredients Plus Dispensing Fee or Charge

Payment for prescribed drugs, whether legend or over-the-counter items, will be made at the lower of the price for ingredients (see 3303.3) plus the dispensing fee on file or the provider's actual amount charged, which shall be the usual and customary charge to the general public.

3303.3 Price for Ingredients

Payment for the ingredients in covered prescriptions is made for two groups of drugs; multiple-source (i.e., therapeutically equivalent or generic drugs) and "other" drugs (i.e., brand name or drugs "other" than multiple-source).

a. For multiple-source drugs, the price for ingredients will be the lowest of:

   1. an amount established as the upper limit derived from a listing issued by CMMS, formerly the Health Care Financing Administration, under the authority of Sec. 902(a)(30)(A) of the Social Security Act, or
   2. an amount established as the upper limit by the Office of Vermont Health Access, or

   3. the Average Wholesale Price (AWP).

b. For "other" drugs, the price for ingredients will be 88.1 percent of the Average Wholesale Price (AWP less 11.9 percent).

3305 Benefit Coverage (Continued)

- insulin and other diabetic supplies, including glucose strips and tablets; and
- needles and syringes.
- one comprehensive visual analysis and one interim eye exam within a two-year period (the refraction code 92015 is subject to prior authorization when the service will be billed by optometrists from July 1, 2002 to June 30, 2003*);
- diagnostic visits and tests;
- dispensing fees (all dispensing fees suspended from July 1, 2002 to June 30, 2003);
- a prescription for frames and lenses every two years (all frames and lenses suspended from July 1, 2002 to June 30, 2003);
- contact and special lenses, when medically necessary and with prior approval (all lenses suspended from July 1, 2002 to June 30, 2003).

* Refraction code 92015 may be billed as a physician's service when the exam is performed by the physician or when performed by a person under the personal supervision of the physician.

Coverage is limited to one pair of glasses every two years per beneficiary. Earlier replacement is limited to the following circumstances.

When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity being compromised.).

When a change of at least one-half diopter in lens strength is documented by the dispensing provider on the Medicaid order form.

The purchase or replacement of eyeglasses shall be through the department's sole source supplier.

Exclusions

No benefits are provided for:

- refills beyond the original and five refills per script up to one year maximum;
- multi-vitamins;
- hair replacement therapies;
- drugs, and contraceptive medications, devices or supplies for which there is no prescription;
- drugs for the sole purpose of fertility; and
- over-the-counter drugs and medicinals.

4001 Eligibility

4001.9 Cost Sharing in Fee-for-Service and Managed Care

4001.92 Copayment

Copayments from individuals receiving VHAP are required for certain services. Section 1916(c) of the Social Security Act stipulates that "no provider participating under the State [Medicaid] plan may deny care or services to an individual eligible for [Medicaid]... on account of such individual's inability to pay [the copayment]." This subsection further provides, however, that these requirements "shall not extinguish the liability of the individual to whom the care or services were furnished for the payment of [the copayment]." This federal statute does not apply to coinsurance, such as coinsurance for prescription drugs.

Service-specific cost-sharing liabilities are:

Physician services:	$7.00 copayment per visit
Other practitioner services:	$7.00 copayment per visit
Physical, occupational, speech and nutrition therapy services:	$7.00 copayment per visit
Hospital Inpatient	$50.00 copayment per admission
Outpatient hospital services not including ER services:	$25.00 per day per hospital
Emergency room:	$25.00 per visit but $60.00 if visit is not a medically necessary emergency, as defined in M103.3 (13) and (37)
Prescription drugs:	60 percent coinsurance per prescription or refill or 50 percent coinsurance when enrolled in managed health care plan.
Chiropractic services	25 percent coinsurance($3.50 per subluxation)
	NOTE: Failure to pay the co-insurance can result in denial of service.

Coinsurance payments are limited to a calendar year maximum of $750 for a single person and $1,500 for VHAP families, when the individual or family is in managed care. The managed health care plan is responsible for letting the individual or family know when they have reached their annual out-of-pocket maximum.

No copayments or coinsurance is required for pregnant women or women in the 60-day post-pregnancy period.

4003 Benefit Delivery Systems

4003.1 Benefits (Continued)

- mental health and chemical dependency services;
  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.
- podiatry services;
- prescription drugs and over-the-counter drugs prescribed by a physician for specific disease or medical condition;
- over-the-counter and prescription smoking cessation with a limit of two treatment regimens per beneficiary per calendar year.

B. Self-Referral Services

In VHAP managed care the following services may be accessed by beneficiaries without a referral from their primary care provider.

- one routine routine annual gynecological exam and related diagnostic services (as specified by the plan);
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required from the plan's mental health and substance abuse in-take coordinator, or primary care physician); and
- one routine eye examination every 24 months. (Coverage is suspended from July 1, 2002 to June 30, 2003).

C. Wrap-Around Benefits

In VHAP managed care, beneficiaries are eligible to receive additional services that are not included in the managed health care plan package. These services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. The wrap-around services are:

- Coverage of limited dental services ends on the later of December 1, 2001, or the Centers for Medicare and Medicaid Services' (CMS), formerly the Health Care Financing Administration, approval date for the elimination of these services from VHAP wrap-around benefits: dental services, excluding dentures, up to an annual calendar-year benefit maximum of $475.
- eyeglasses furnished through PATH’s sole source contractor (Coverage is suspended from July 1, 2002 to June 30, 2003);
- chiropractic services;
- family planning services (defined as those services that either prevent or delay pregnancy).

M670 Eyeglasses and Vision Care Services

See M670.3 for limits on coverage from July 1, 2002 to June 30, 2003.

M670.1 Definition

Eyeglasses and vision care services are those services requiring the application of theories, principles and procedures related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. This definition is consistent with the federal definition of services found at 42 CFR §440.60(a), 440.120(d), and 441.30.

M670.2 Eligibility for Care

Coverage of eyeglasses and vision care services is provided to beneficiaries of any age.

M670.3 Covered Services

Eyeglasses and vision care services that have been pre-approved for coverage are limited to:

- one comprehensive visual analysis and one interim eye exam within a two-year period (the refraction code 92015 for beneficiaries age 21 and older is subject to prior authorization when the service will be billed by optometrists from July 1, 2002 to June 30, 2003*);
- diagnostic visits and tests;
- dispensing fees (all dispensing fees for beneficiaries age 21and older suspended from July 1, 2002 to June 30, 2003);
- a prescription for frames and lenses every two years (all frames and lenses for beneficiaries age 21 and older suspended from July 1, 2002 to June 30, 2003);
- contact and special lenses, when medically necessary and with prior approval (all lenses for beneficiaries age 21 and older suspended from July 1, 2002 to June 30, 2003); and
- other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

*Refraction code 92015 may be billed as a physician's service when the exam is performed by the physician or when performed by a person under the personal supervision of the physician.

M670.4 Conditions for Coverage

Coverage is limited to one pair of glasses every two years per beneficiary. Earlier replacement is limited to the following circumstances.

When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. (Dispensing providers will make the decision about being broken beyond repair or visual acuity being compromised.)